NC Medicaid Managed Care
Provider Playbook

NC Medicaid

To ensure beneficiaries can seamlessly receive care on day one, the North Carolina Department of Health and Human Services (NCDHHS) is delaying the implementation of the NC Medicaid Managed Care Behavioral Health and Intellectual/ Developmental Disabilities Tailored Plans (Tailored Plans). Tailored Plan launch was scheduled for Oct. 1, 2023, **but will now go forward at a date still to be determined.**

Fact Sheet

Tailored Plan Provider Contracting Deadlines Questions and Answers

WHAT IS CHANGING ?

To be included in the Enrollment Broker's Medicaid Health Plan and Provider Lookup Tool at the start of the Tailored Plan beneficiary choice period, provider contracts must be signed and returned to the Tailored Plan.

WHY ARE THESE CHANGES HAPPENING ?

It often takes Tailored Plans at least two to three weeks to process provider contracts and ensure that providers can be paid. Additional time is then needed to transmit information to the Department to be included in the beneficiary choice period, Provider Lookup Tool and in the auto-assignment process.

WHO IS IMPACTED ?

All Medicaid providers who want beneficiaries to be able to select them as a primary care provider (PCP) during beneficiary choice period or to be assigned as a PCP and/or Tailored Care Management provider through auto-assignment, and to be reimbursed appropriately on day one of Tailored Plan launch.

WHY IS IT IMPORTANT TO CONTRACT WITH TAILORED PLANS IN ADVANCE OF THE BENEFICIARY CHOICE PERIOD AND AUTO-ASSIGNMENT?

- PCPs who do not contract with Tailored Plans by the deadlines will limit the number of beneficiaries that either select them during the beneficiary choice period or who are assigned to them through PCP auto-assignment prior to Tailored Plan launch.
- Existing PCPs in particular risk losing patients on current patient panels, as beneficiaries may select only in-network (contracted) PCPs during the beneficiary choice period and the Department will auto-assign beneficiaries to only in-network providers.
- Advanced Medical Homes (AMHs) that do not contract with Tailored Plans in time may also miss earning per member per month (PMPM) medical home payments through the AMH program.

ARE PROVIDERS REQUIRED TO CONTRACT WITH ALL TAILORED PLANS?

No. Providers may contract with as few or as many Tailored Plans as they prefer. However, patients can select only in-network providers during the beneficiary choice period and will be auto-assigned to only in-network providers for their Tailored Plan.

WHAT ARE TAILORED PLANS' RESPONSIBILTIES WITH RESPECT TO CONTRACTING WITH MEDICAID PROVIDERS ?

- The Department acknowledges that contracts between providers and Tailored Plans are long-term agreements with many components and recognizes that health systems have to exercise due diligence in getting to a contract that is right for both the provider and the Tailored Plan.
- The Department expects Tailored Plans to negotiate with any willing provider of physical health care services and pharmacy services in good faith.
- All providers of health care services must be enrolled in NC Medicaid to be considered for contracting by a Tailored Plan. Tailored Plans may exclude qualified physical health care providers (including PCP/AMHs) from their networks only when a provider refuses to accept network rates.
- For behavioral health, Intellectual/Developmental Disabilities (I/DD) and traumatic brain injury (TBI) providers, Tailored Plans may have a closed network, which means the Tailored Plan may exclude providers who do not meet the Tailored Plan's participation requirements.

WHAT ARE REQUIRED PAYMENTS FOR AMHS, A TYPE OF PCP?

- Tailored Plans must reimburse in-network physicians and physician extenders no less than 100% of NC Medicaid Direct (fee-for-service) rates unless they have mutually agreed to an alternative arrangement.

- In addition to NC Medicaid Direct payments, Tailored Plans are required to pay medical home fees to Advanced Medical Homes Tiers 1, 2, 3s/ and AMH+.
- Tailored Plans are able to also offer quality incentive payments to all AMH Tier 3s.
- In Tailored Plans, only AMH+ can bill for providing tailored care management and receive associated care management payments based on their assigned tailored care management panel.

WHEN IS THE BENEFICIARY CHOICE PERIOD AND AUTO-ENROLLMENT?

- Beneficiaries in all managed care regions will be aligned to a designated Tailored Plan in their region. They will then have the option to choose a PCP during the Tailored Plan beneficiary choice period.
- Beneficiaries may keep their current PCP/AMH by selecting the provider as their PCP.
- After the beneficiary choice period closes, beneficiaries who have not chosen a PCP will be automatically assigned one by the Department (auto-assignment).
- PCP auto-assignment will be completed before the Tailored Plans mail Medicaid ID cards, which will be mailed to beneficiaries by Sept. 8, 2023. Beneficiaries who are already assigned to their preferred TCM provider will continue to be assigned to that provider when Tailored Plan launches.
- After launch new beneficiaries must be assigned to a PCP and Tailored Care Management (TCM) provider within 24 hours of being enrolled in the Tailored Plan. Tailored Plans must mail an ID card within eight days of PCP and TCM auto-assignment.

HOW SOON AFTER FINALIZING A CONTRACT WITH A TAILORED PLAN WILL I SHOW UP IN THE ENROLLMENT BROKER MEDICAID AND HEALTH CHOICE HEALTH PLAN PROVIDER LOOKUP TOOL AS IN-NETWORK WITH THAT TAILORED PLAN?

- Once the contracting process is complete and the provider has delivered all the required demographic information to the Tailored Plan, it takes at least two to three weeks but may take longer to load a provider into the Tailored Plan's system and begin showing as an in-network provider. A provider can help expedite this process by beginning to share physician roster information with the Tailored Plan in advance of finalizing their contract. This allows the Tailored Plan to begin processing this information and be prepared to enroll a provider more quickly.
- It is important to the Department that a provider does not show up as in-network with a Tailored Plan until such point that the Tailored Plan can make payments to that provider. This ensures that both the beneficiary and provider have the most accurate information about where to seek care and ensure timely payment for services.
- Providers also must ensure that data in NCTracks are accurate. To make changes to your NCTracks provider record, a provider must submit a Manage Change Request from the Status and Management page of the NCTracks provider portal. Providers should review each page and confirm that service locations (address/phone number), taxonomies, patient restrictions

and office hours are correct. There is a minimum of five business days after the Managed Change Request is approved before the updates will appear on the Enrollment Broker Medicaid Provider Lookup Tool.

IF I AM UNABLE TO FINALIZE MY TAILORED PLAN CONTRACTS BY THE DEADLINES, SHOULD I STILL PURSUE CONTRACTING WITH A TAILORED PLAN?

- Yes. Providers are encouraged to continue contract negotiations with Tailored Plans and finalize the contract as soon as possible. It is important for contracts to be in place prior to launch, to ensure that you can continue to serve Medicaid beneficiaries and be reimbursed appropriately on day one.
- When health systems or providers successfully execute contracts with a Tailored Plan, they become in-network providers with that Tailored Plan.
- If I am unable to finalize my Tailored Plan contracts by the deadlines, but I do finalize my Tailored Plan contracts before launch, will my patients be able to select me as their PCP? How?
- Each year, beneficiaries are given 30 calendar days from the date they receive their PCP assignment to change their PCP without cause. Beneficiaries are allowed one additional without-cause change each year. Beneficiaries are allowed to change their PCP with cause at any time.
- Additionally, the Department is planning to extend the initial 30-day period after Tailored Plan launch. The extended duration will be confirmed when a new Tailored Plan launch date is set..
- Members of federally recognized tribes may change their PCP without cause at any time.
- Beneficiaries may call their Tailored Plan and select a PCP different from the one they received during auto-assignment.
- When health systems or providers can finalize negotiations with a Tailored Plan, they become in-network providers with that Tailored Plan. In-network PCPs can then be assigned beneficiaries according to their panel limit agreements with Tailored Plans. Contact the Tailored Plan directly for more information on contracting.

IF I AM UNABLE TO FINALIZE MY TAILORED PLAN CONTRACTS BY THE SPECIFIC DEADLINES, BUT I DO FINALIZE MY TAILORED PLAN CONTRACTS BEFORE, WILL BENEFICIARIES BE ABLE TO SELECT ME AS THEIR TAILORED CARE MANAGEMENT PROVIDER? HOW?

- After launch, beneficiaries can change their TCM provider twice a year without cause and anytime with cause. Beneficiaries may call their Tailored Plan and select a TCM different from the one they received during auto-assignment.
- When TCM providers can complete readiness reviews and finalize contracts with a Tailored

Plan, they become in-network providers with that Tailored plan. In-network TCM providers can then be assigned beneficiaries according to their panel limit agreements with Tailored Plans. Contact the Tailored Plan directly for more information on contracting with a Tailored Plan. Contact information is located on the Medicaid website at Health Plans | NC Medicaid (ncdhhs.gov).